Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Dental and Vision Enrollment and Change Form (FORM -1)

FOR MANAGERS, CONFIDENTIAL EMPLOYEES, THE LEGISLATURE, CONSTITUTIONAL OFFICES AND THEIR STAFF ONLY. EMPLOYEES SUBJECT TO COLLECTIVE BARGAINING AND EMPLOYEES IN HIGHER EDUCATION, THE JUDICIAL COURT SYSTEM, AND OF AUTHORITIES ARE NOT ELIGIBLE

PLEASE TYPE OR PRINT CLEARLY

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		___ / ___ / ___	/

Name - Last | First | MI

Address: (Number and Street) This is a new Address ☐

City | State | Zip Code | Foreign Country

Date Entered Service: ____ / ____ / ____ | Home Phone: ( ) | Work Phone: ( )

02 **NEW ENROLLMENT** ☐ **PROMOTION** ☐ **CHANGE** ☐ **CANCEL COVERAGE** ☐

EFFECTIVE DATE _____ **/ 01 /** _____

Type of Coverage

Individual ☐ Family ☐

Dental Benefit (Please check One)

☐ Indemnity Plan (DeltaPremier)
☐ PPO Plan (DeltaPreferred)

I understand that I may not change this plan type until the next annual enrollment period.

Vision Benefit (Select Provider at Time of Service)

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

List below all family members, including your spouse, who will be covered under your dental and vision family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. Attach separate sheet if additional space is required.

Important: The Group Insurance Commission reserves the right to require you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent. This proof may be requested at any time.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective Date: _____

03 ☐ **Name Change** | Previous Name: | New Name:

LEAVE OF ABSENCE

04 ☐ **Leave Is:** With Pay ☐ Without Pay ☐ **GIC USE ONLY:** Leave Pay Status: Part ☐ Full ☐ Other ☐

Leave Type (You MUST Check one of the following):

____ Educational *____ Industrial Accident* *____ Personal Illness ____ Suspension
____ Family (for dep < age 3) *____ Maternity ____ Personal Reason ____ FMLA
____ Family (for dep > age 3) ____ Military ____ Sabbatical ____ Other

*Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date: ___ / ___ / ___ End Date: ___ / ___ / ___

Last Day on Payroll: _____ / _____ / _____

05 ☐ **Return to Payroll Deduction**: First Day Back in Payroll: _____ / _____ / _____

INSURED CHANGES

06 ☐	**Retirement**	Date Retired ____ / _____ / ____	
07 ☐	**Transfer to another Agency**	Name of Agency Transferred to	Effective Date
08 ☐	**Transfer from another Agency**	Previous Agency	Effective Date
09 ☐	**Termination**	Termination Reason	Termination Date ____ / _____ / ____

PLEASE READ CAREFULLY

Eligibility: I understand that only managers, confidential employees, the legislature, constitutional offices and their staff are eligible for this program. I am an employee that falls into one of these categories and I am not employed by higher education, the judicial court system, and/or an authority.

Deduction Authorization: I authorize my employer to deduct from my payroll check the amount required for the dental and vision coverage I have selected.

X _____ _____
Signature of Applicant Date

X _____ _____
Signature of Authorized Official Date

FOR GIC USE ONLY

ENTERED	VERIFIED	

RETURN COMPLETED FORM TO YOUR GIC COORDINATOR